

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13644

CERTIFICATE OF DEATH

Reg. Dist. No.

13624

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physician Memorial Hosp</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>EDNA</i>		First <i>EDNA</i>	Middle <i></i>
4. DATE OF DEATH <i>ADAMS</i>		Month <i>DEC</i>	Day <i>25</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH <i>Sept 29 1902</i>		9. AGE (In years lost birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>self</i>	
11. BIRTHPLACE (State or foreign country) <i>Ma.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A</i>	
13. FATHER'S NAME <i>Edgar Atchison</i>		14. MOTHER'S MAIDEN NAME <i>Elyzabeth Padgett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Magruder Adams</i>		Address <i>Waldorf Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>916.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Burns <i>4 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Rehal Failure</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Reas caught fire at home</i>	
20c. TIME OF INJURY Hour <i>9 p.m.</i>		Month <i>12 - 2015</i>	Day, Year <i>1959</i>
20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20f. (City or town) <i>Waldorf Charles Md.</i>		(County) <i>Charles</i>	
(State) <i>MD</i>			
21. I certify that I attended the deceased from <i>12-20</i> , 19 <i>59</i> , to <i>12-25</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12-25</i> , 19 <i>59</i> , and that death occurred at <i>1154</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>F.M. Johnson</i>		ADDRESS (Street, city or town, state) <i>La Plata, Md. 12-25-59</i>	
PHYSICIAN'S NAME (Type) <i>F.M. Johnson MD.</i>		DATE SIGNED <i>12-25-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-28-59</i>	22c. NAME OF CEMETERY OR CEMMATORY <i>St. George</i>
22d. LOCATION (City, town, or county) <i>Pomfret, Md</i>		(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wontt Funeral Home, Waldorf Md.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 30 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

CERTIFICATE OF DEATH

Date of Birth

Date of Death

Cause of Death

Signature

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13625

CERTIFICATE OF DEATH

13645

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CHARLES	
TOWN		87 yrs		X		Bryans Road	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
Sarah Elizabeth Briscoe				(If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
Female Colored				widowed		FEB 19, 1879	
9. AGE last birthday yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
80		Housewife		own home		Port Tobacco, St. Mary's Co.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Richard Calvert				Mary Rebecca Campbell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.			
No				720			
17. INFORMANT & ADDRESS				18. MEDICAL CERTIFICATION			
Eliza Neal, Bryans Road, St. Mary's Co.				Hypertensive Heart Disease			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
443X IMMEDIATE CAUSE (A)				94 yrs.			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from 12/15/59, to 12/6/59, that I last saw the deceased alive on 12/15/59, and that death occurred at 1:30 A.M., from the causes and on the date stated above. SIGNATURE <i>Frank G. Fusion</i> M.D. ADDRESS (Street, city, town, state) <i>Indian Head, St. Mary's Co.</i> DATE SIGNED <i>12/6/59</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF			
Burial				12-9-59			
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE			
DATE DEC 10 '59				Arthur S. House			
25. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
				<i>Hurst Funeral Home, Walney</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13646

CERTIFICATE OF DEATH

Reg. Dist. No.

13626

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be filed with the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md		c. LENGTH OF STAY IN 1b 7-yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md		d. STREET ADDRESS Rt-1-Bx.61-Indian Head Md				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Charles	Middle Edward	Lost	4. DATE OF DEATH 12-6-59	Month 12	Day 6	Year 1959		
5. SEX Male	6. COLOR OR RACE W-US	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-29-16		9. AGE (In years lost birthday) 43	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter		10b. KIND OF BUSINESS OR INDUSTRY Naval Propellant Plant Indian Head Md		11. BIRTHPLACE (State or foreign country) New Brunswick N.J.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Charles Edward Burleson		14. MOTHER'S MAIDEN NAME M. Florence McEvoy								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) USN-Yes		16. SOCIAL SECURITY NO. 1944-1945 009-03-0285		17. INFORMANT Wife - Mrs Charles E. Burleson		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1		3-Hours								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arterio Sclerosis		Indefinite								
DUE TO DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Doy, Year 5-PM o.m. 12-6-59 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 12-6-59		(County)	(State)	
21. I certify that I attended the deceased from 1-1-59, 19, to 12-6-59, 19, that I last saw the deceased alive on 12-6-59, 19, and that death occurred at 5-PM M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)							DATE SIGNED	
ACTUAL SIGNATURE James E. Andrews		M.D. 17-Potomac Ave-Indian Head Md. 12-7-59								
PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/59		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Archard Funeral Home, Inc. - Lab Plata, Md.		ADDRESS		24a. REC'D BY REGISTRAR DEC 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

CERTIFICATE OF DEATH

Baltimore

BALTIMORE, MARYLAND, DECEMBER 18, 1918.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13647

CERTIFICATE OF DEATH

Reg. Dist. No. 13627

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brandywine</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Memorial</i>		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Madoria</i>	Middle <i>Mary</i>	4. DATE OF DEATH <i>Dec 21</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Dec 16, 1923</i>
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <i>36</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Lunch Room</i>	
11. BIRTHPLACE (State or foreign country) <i>Massachusetts</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Alfred Carpenter</i>		14. MOTHER'S MAIDEN NAME <i>Josephine ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yer. no. or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>031-18-4943</i>	
17. INFORMANT <i>Alfred Carpenter, Brandywine, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>592 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) <i>CHRONIC NEPHRITIS</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
		2 days	
		?	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12-12</i> , 19 <i>57</i> , to <i>12-21</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>12-21</i> , 19 <i>57</i> , and that death occurred at <i>9:30 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> DATE SIGNED <i>12-23-57</i>	
ACTUAL SIGNATURE <i>J. J. Danner</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>F. M. Johnson M.D.</i>		22d. LOCATION (City, town, or county) (State) <i>Upper Marlboro, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-24-59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Carmel</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 28 '59</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The United Funeral Home, Waldorf, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

CERTIFICATE OF DEATH

MAY 1950

APRIL 1950

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13628

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE					
CHARLES MARYLAND		MD. CHAS					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b					
LA PLATA MD		X LAPLATA.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS					
OHYS MEM. HOSP.							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH First Middle Last Month Day Year					
HANNAH O COOMBS		12 16 1959					
5. SEX		6. COLOR OR RACE					
F		C					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH					
WIDOWED <input type="checkbox"/>		9. AGE (in years last birthday) 61 yrs.					
DIVORCED <input type="checkbox"/>		10. KIND OF BUSINESS OR INDUSTRY					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (State or foreign country) Md.					
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert J. JOHNSON		14. MOTHER'S MAIDEN NAME EFFIE NATES					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.					
17. INFORMANT HILDEGARD ADAMS		Address AQUASCO 180.					
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO <u>Coronary Occlusion</u> INTERVAL BETWEEN ONSET AND DEATH 12-16-59							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Gen. Art Sclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Charles Co. Md.		(County)		(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE E. J. Edelen		DATE SIGNED 12-17-59					
EXAMINER'S NAME (Type) E. J. Edelen		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/20/59		22c. NAME OF CEMETERY OR CREMATORIAL Newtown Cem		22d. LOCATION (City, town, or county) Charles Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George L. Nelson		ADDRESS Liquor Store Md.		24a. REC'D BY REGISTRAR DEC 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13649

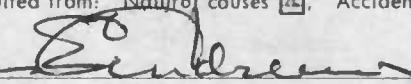
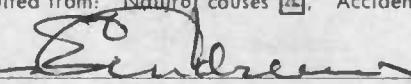
Reg. Dist. No.

13629

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a Burial-Transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V8. 5M 2/57

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md.		c. LENGTH OF STAY IN lb 57-Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Margeret	Middle Ann	Lost	4. DATE OF DEATH 12-30-59	Month 12	Day 30	Year 59
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4-16-1902	9. AGE (In years from birthday) 57 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Edward King		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-34-9587 17. INFORMANT Daughter—Mabel Baker		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1948 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Carcinoma Uterus				Address INTERVAL BETWEEN ONSET AND DEATH 2-Yrs		
		(b) General Metastases				6-11ths.		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Patient was in John Hopkins Hospital Baltimore for ten weeks where she was operated on for Uterine Cancer, She was discharged 11-25-59				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Pleasant Grove	(County) Charles Co	(State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-30-59		
ACTUAL SIGNATURE 		EXAMINER'S NAME (Type) James E. Andrews						
22a. BURIAL OR CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 1/3/60	22c. NAME OF CEMETERY OR CREMATORIAL Pleasant Grove	22d. LOCATION (City, town, or county) Charles Co Md		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS 4404 Belvoir Rd	24a. REC'D BY REGISTRAR PC JAN 4 '60	24b. REGISTRAR'S SIGNATURE C. Lang S. Kraus				

1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13630

1. PLACE OF DEATH a. COUNTY		13650 Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE Md.		b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Grayton		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First JANIE		Middle ALICE		Last Hancock		4. DATE OF DEATH Dec		Month 6		Year 1959	
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 20 1870		9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Own Home		12. CITIZEN OF WHAT COUNTRY? Maryland							
13. FATHER'S NAME Ogerton Bradshaw		14. MOTHER'S MAIDEN NAME Jane Rye											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Dorothy Hancock		Address Grayton, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X		acute cardiac dilatation 20 mm											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		cardiac failure 5 years.											
DUE TO (c)		Hypertension 8 years.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) La Plata, Md.		(County) Md.		(State) Md.			
21. I certify that I attended the deceased from 4-25, 1956, to 12-6, 1957, that I last saw the deceased alive on 9-3, 1959, and that death occurred at 10 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) La Plata, Md.		DATE SIGNED 12-8-59									
ACTUAL SIGNATURE F.M. Johnson M.D.													
PHYSICIAN'S NAME (Type)													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-8-59		22c. NAME OF CEMETERY OR CREMATORIAL Private Family Cemetery		22d. LOCATION (City, town, or county) Grayton, Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		ADDRESS		24a. REC'D BY REGISTRAR DEC 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, one funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13651

CERTIFICATE OF DEATH

Reg. Dist. No.

13631

1. PLACE OF DEATH a. COUNTY CHARLES		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md		b. COUNTY CHARLES		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA		d. STREET ADDRESS Md		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR-INSTITUTION PHY MEM. HOSP				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First DOROTHY	Middle HEENE	Lost JENKINS	4. DATE OF DEATH Dec 17 1959	Month Dec	Day 17	Year 1959
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH APRIL 11, 1907 52	9. AGE (In years last birthday) yrs. 52	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SAW		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Jacob Heiner		14. MOTHER'S-MAIDEN NAME Mary Herrmann				Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, unknown) NO		16. SOCIAL SECURITY NO. yes		17. INFORMANT Frank P. Jenkins, Laplata Md		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9-59
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ACTUAL SIGNATURE E.J. EdeLEN		ADDRESS (Street, city or town, state) La Plata, Md. 12/18/59						
PHYSICIAN'S NAME (Type) E.J. EDELEN		DATE SIGNED 12/18/59						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/59		22c. NAME OF CEMETERY OR CREMATORIAL St. Ignatius		22d. LOCATION (City, town, or county) (State) La Plata, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Michael J. EdeLEN		ADDRESS La Plata, Maryland		24a. REC'D BY REGISTRAR DATE DEC 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kuhn		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1
FOR STATE
HEALTH DEPT.

Items 11, 13, 14, 18 File 254-1-18-60 ams

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14358

1. PLACE OF DEATH 13652 a. COUNTY Charles	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Charles					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head	c. LENGTH OF STAY IN lb Indian Head					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Indian Head	d. STREET ADDRESS					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) BABY	First JOHNSON Middle Last	4. DATE OF DEATH December 8 1959	Month Day Year			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/18/59	9. AGE (In years last birthday) 1 yrs.	IF UNDER 1 YEAR 1 Months	IF UNDER 24 HRS. 14 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pomonkey, Maryland	12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 525X DUE TO Interstitial pneumonitis INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>W. Bradley King, Jr.</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12/9/59	
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.	M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremated at Morgue 12-9	22b. DATE THEREOF 9VVVVVVXVU	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	22d. LOCATION (City, town, or country) Address (Street, city, town, or county)	(State)		
23. FUNERAL DIRECTOR Arthur S. Kraus	ADDRESS	24a. REC'D BY REGISTRAR JAN 12 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 7/2 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13653

CERTIFICATE OF DEATH

Reg. Dist. No. 13652

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata,		c. LENGTH OF STAY IN 1b /	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION none		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata	
d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY		4. DATE OF DEATH Dec 12 1957	
S. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17 1912
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor		10b. KIND OF BUSINESS OR INDUSTRY State Road	
11. BIRTHPLACE (State or foreign country) La Plata, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Johnson		14. MOTHER'S MAIDEN NAME Julia	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 214-18-8586	
17. INFORMANT Julia Johnson, La Plata, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1958, to 12 Dec 1957, that I last saw the deceased alive on _____, 1959, and that death occurred at 3:45 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE F. M. Johnson M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12 16 59	
22c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart Cemetery		22d. LOCATION (City, town, or county) La Plata, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home		ADDRESS Waldorf, Md.	
24a. REC'D BY REGISTRAR DATE DEC 17 '59		24b. REGISTRAR'S SIGNATURE John S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13654 CERTIFICATE OF DEATH

Reg. Dist. No. 13633

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians' Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Welcome	
3. NAME OF DECEASED (Type or print) Walter		4. DATE OF DEATH December 12	
First Walter	Middle Jenifer	Last Jones	Month December
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 13, 1911
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 48 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augusta Jones		14. MOTHER'S MAIDEN NAME Elizabeth Barnes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217 30 1158	
17. INFORMANT Mc Carthey Greer, Welcome, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous Intraventricular Hemorrhage			
443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Following Right Cerebral Hemorrhage			
DUE TO (c) Hypertensive Arteriosclerotic Vascular Dis. years			
15 days			
INTERVAL BETWEEN ONSET AND DEATH 2 min.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) No accident		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Spontaneous onset at home.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:00 a.m. Nov. 28 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Welcome, Charles, Md.	
21. I certify that I attended the deceased from 11-28 , 19 59 , to 12-12 , 19 59 , that I last saw the deceased alive on 12-12-59 , 19 59 , and that death occurred at 9:50 AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Box 397, La Plata, Md.			
DATE SIGNED 12-14-59.			
ACTUAL SIGNATURE V.B. Dettor		M.D.	
PHYSICIAN'S NAME (Type) V.B. Dettor, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-15-1959	
22c. NAME OF CEMETERY OR CREMATORIAL Zion Baptist Cemetery		22d. LOCATION (City, town, or county) Welcome, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home		ADDRESS Waldorf, Md.	
24a. REC'D BY REGISTRAR DATE DEC 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1020	1021	1022	1023	10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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13634

1. PLACE OF DEATH a. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NANJEMOY		c. LENGTH OF STAY IN b 6 mo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NANJEMOY	
d. STREET ADDRESS —		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RICKY		First C	Middle ORTEZ
3. NAME OF DECEASED (Type or print) RICKY		Last K	4. DATE OF DEATH DEC. 14 1959
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-18-59
9. AGE (In years last birthday) 5 yrs.	10. IF UNDER 1 YEAR 5 months	11. IF UNDER 24 HRS. 26 days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME THEODORE KEYS		14. MOTHER'S MAIDEN NAME EVELYN JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT THEODORE KEYS, NANJEMOY, MD.		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 921.0			
DUE TO Asphyxiation			
INTERVAL BETWEEN ONSET AND DEATH 1 min.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aspiration of vomitus			
DUE TO none			
INTERVAL BETWEEN ONSET AND DEATH 1 min.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Vomited in bed after taking formula	
20c. TIME OF INJURY Hour 5:45 p.m.		Month, Day, Year 12-14 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Nanjemoy, Charles, Md.	(County) —
20g. (State) —			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE V.B. Dettor		DATE SIGNED 12-14-59	
EXAMINER'S NAME (Type) V.B. DETTOR, MD.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/14/59	
22c. NAME OF CEMETERY OR CREMATORIAL MT. HOPE BAPTIST CHURCH		22d. LOCATION (City, town, or county) NANJEMOY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Chenhart Funeral Home, Inc. - La Plata, MD		24a. REC'D BY REGISTRAR DATE DEC 23 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 13635

13636

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b 2 1/2 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First DEBORAH	Middle S.	Last KILGORE	4. DATE OF DEATH December	Month 26	Day 1959	Year
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 11, 1959	9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) La Plata, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Edward Kilgore	14. MOTHER'S MAIDEN NAME Blanch Kiser
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Edward Kilgore - La Plata, Md.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 475 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Died during sleep - previously well				
20c. TIME OF INJURY Month, Day, Year Hour 12:30 a.m. 12-26 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) La Plata	(County) Charles	(State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>					
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ACTUAL SIGNATURE V.B. Dettor	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 12-26-59
EXAMINER'S NAME (Type) V.B. DETTOR, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/27/1959	22c. NAME OF CEMETERY OR CREMATORIAL Methodist Cemetery	22d. LOCATION (City, town, or county) Dentsville	(State) Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE Archard Funeral Home, Inc.	ADDRESS La Plata, Md.	24a. REC'D BY REGISTRAR DATE DEC 29 '59	24b. REGISTRAR'S SIGNATURE Charles S. Kraus
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the same in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF OREGON
REGISTRATION OF MOTOR VEHICLES

REGISTRATION

EXPIRATION DATE

REGISTRATION

EXPIRATION DATE

REGISTRATION EXPIRATION DATE

EXPIRATION DATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13657

CERTIFICATE OF DEATH

Reg. Dist. No.

13636

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marbury		c. LENGTH OF STAY IN 1b 45-Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marbury					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) James Albert Murdock		First	Middle	Last	4. DATE OF DEATH 12-22-59	Month	Day	Year 19	
5. SEX Male	6. COLOR OR RACE W-US	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-7-1890		9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tin-Smith-Rt.		10b. KIND OF BUSINESS OR INDUSTRY US-Government		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James E. Murdock		14. MOTHER'S MAIDEN NAME Priscilla Henderson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James G. Murdock, (Son)		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Metastesis to Perineum with ulceration DUE TO (c) Malnutrition						INTERVAL BETWEEN ONSET AND DEATH 2-Yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Patient was unable to handle sufficient nourishment for about 6-Mths.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
21. I certify that I attended the deceased from 1-1-57, 19, to 12-22-59, 19, that I last saw the deceased alive on 12-22-59, 19, and that death occurred at 8 PM M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12-23-59 DATE SIGNED									
ACTUAL SIGNATURE James E. Andrews		M.D.							
PHYSICIAN'S NAME (Type)		James E. Andrews, 17-Potomac Ave. Indian Head Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-59		22c. NAME OF CEMETERY OR CREMATORIUM Marbury Baptist		22d. LOCATION (City, town, or county) (State) Marbury, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		ADDRESS		24a. REC'D BY REGISTRAR DEC 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G254 1-4-60 et

13653

CERTIFICATE OF DEATH

Reg. Dist. No.

13637

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		c. LENGTH OF STAY IN 1b none				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION none		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf				
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Myrtle	Middle Walton			
4. DATE OF DEATH		Month Dec.	Day 26			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH		1875	9. AGE (In years last birthday) 84 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Va.			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Richard Walton				
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Norman Fisher, Waldorf, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Failure</i> DUE TO <i>502!</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Chronic C-V.R. Failure</i> DUE TO <i>Chronic Bronchitis</i> years (c) <i>Chronic Bronchitis</i> years						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Chronic Arthritis</i>				
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Agawam Ind</i>	(County) <i>Agawam Ind</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <u>12/19/57</u> , 19 <u>57</u> , to <u>12/26/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/18/57</u> , 19 <u>57</u> , and that death occurred at <u>4:25 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Taher M. Seron M.D.</u> ADDRESS (Street, city or town, state) <u>Agawam Ind</u> DATE SIGNED <u>12/27/57</u>						
PHYSICIAN'S NAME (Type) <u>V. M. Seron M.D.</u>						
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 12-29-59	22c. NAME OF CEMETERY OR CREMATORIAL Vernona Cemetery	22d. LOCATION (City, town, or county) Vernona Va. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home, Waldorf, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE DEC 30 '59	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

CERTIFICATE OF DEATH

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